DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/15/2011	
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE LAGRANGE ROAD /ER, IN47243		
(X4) ID PREFIX TAG F0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	State Licensure S Survey dates: Ju 2011 Facility number: Provider number AIM number: 10 Survey Team: Donna Groan RN	ly 11, 12, 13, 14, 15, 000115 : 155208 00291080 N, TC EN [July 11, 12, 13, 14, RN SW	FO	0000	Submission of this Plan of Correction does not const admission or agreement by provider of the truth of fact alleged or correction set from the state of deficiencies. This Plan of Correction is prepared and submitted because of requires of State Federal law. Please accept plan of correction as our credible allegation of compliance.	itute y the ts orth s.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PMLR11

Facility ID:

000115

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/15/2011	
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			410 W	ADDRESS, CITY, STATE, ZIP CODE LAGRANGE ROAD /ER, IN47243	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	findings in accor Quality review 7/22	es also reflect state dance with 410 IAC 16.2.			
F0157 SS=D	resident; consult wand if known, notification representative or a when there is an a resident which respotential for requiring significant changemental, or psychosocial statuconditions or clinical tertreatment significant conditions or clinical tertreatment signification in the psychosocial statuconditions or clinical tertreatment signification in the psychosocial statuconditions or clinical tertreatment signification in the significant reatment signification in the facility as specified. The facility must a resident and, if known there is a change in resident state law or regular paragraph (b)(1) of the facility must resident the address the significant resident significa	is in either life threatening all complications); a need to inificantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the pwn, the resident's legal interested family member ange in room or roommate accified in §483.15(e)(2); or ent rights under Federal or ations as specified in			
	A. Based on reco the facility failed and responsible p	ord review and interview, to notify the physician party when a resident had pisode of choking while	F0157	The facility will ensure this requirement is met through following corrective measu 1. Resident number #52's family and physician were	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155208 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE ROAD HANOVER NURSING CENTER HANOVER, IN47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE notified of the episode of the eating. This deficient practice affected 1 resident getting choked up. of 1 resident who experienced a choking Resident number #22's family episode while eating in a sample of 15 and physician have been residents. (Resident #52) notified that the PT. OT. and ST assessment had not been B. Based on record review, interview and completed timely. Resident #1's family and physician were observation, the facility failed to notify notified that the order for the physician or family an assessment had footwear was not addressed not been completed as ordered for timely. Resident #91 deceased. physical therapy (P.T.), occupational 2. All residents have the therapy (O.T.) and speech therapy (S.T.) potential to be affected. Nurse' s Notes reviewed for past 30 for 1 of 3 residents reviewed for therapy days to ensure in a sample of 15. (Resident #22) physician/family notification made when indicated. 3. a. C. Based on record review, observation and The physician/family interview, the facility failed to ensure a the notification with acute changes physician was notified of an order for footwear in condition policy and which was not obtained for 1 of 1 resident procedure was reviewed and reviewed for footwear in a resident sample of 15 no changes were indicated at and failed to notify the physician/family this time (see attachment A). medication was not provided as ordered for 1 of Licensed staff were 15 residents reviewed for medication re-educated on the procedure. administration in the sample of 15. (Resident #1, The DON or her designee will #91) review Nurse's Notes daily on scheduled work days to ensure Findings include: physicians and family members are notified timely A.1. Review of the clinical record for with changes in condition indefinitely. (See Resident #52 on 7/13/2011 at 9:50 a.m., attachment B). b. The indicated the resident had diagnoses medication administration which included, but were not limited to, policy was reviewed and no multi-infarct dementia, cataracts, and changes were indicated (see status post cerebral vascular accident attachment I). Licensed staff were re-educated on that (stroke). policy. The DON or her designee will audit MAR's three

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED 07/15/2011	
		155208	B. WING	_		07/15/2	U11
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
	ER NURSING CENT	·CD			AGRANGE ROAD		
					ER, IN47243		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
1710				mo	times weekly for four week		DATE
	Review of the nursing notes between 3/1/2011 and 7/13/2011, the following				then twice weekly for four		
	entry was noted:	5/2011, the following			weeks, then weekly for four		
	l *	p.m.]: when feeding res			weeks then monthly therea	fter	
		this evening, res. noted			to ensure medications are		
]	•			administered as ordered (s attachment Z). c. The polici		
	noted to lean hea	on liquids & food. Res			related to Physician Orders		
	repositioned repe				therapy screens were review	red	
		vas lacking of the			and no changes were indica		
		e responsible party having			this time (see attachments J Sa). The DON or her design		
	been notified of t				will review all new physician		
		ine episode.			orders daily on scheduled we	ork	
	During on intervi	iew with the Director of			days indefinitely to ensure follow		
	~				through (see attachment B). Administrator or her designe		
		on 7/13/2011 at 2:00 p.m., the resident has a			review all therapy screen	e wiii	
					requests daily on scheduled	work	
		th and some staff will			days indefinitely to ensure		
		g. She further indicated			screens are completed timel		
	not been notified	l responsible party had			(see attachment Sb). 4. Findings of these audits wi	ll he	
	not been notified	of the incident.			reviewed during the facility		
	On 7/14/2011 at	1.25 41			quarterly quality assurance		
	On 7/14/2011 at	-			meetings and the plan of ac		
	1	esented a copy of the			adjusted accordingly. 5. Th		
	l *	policy on "Physician &			above corrective measures be completed on or before	WIII	
	1	ion Procedure". Review			August 14th, 2011.		
		his time included, but was			J , 		
		Purpose: To keep the					
	1 * *	nt, and family appraised					
		hanges. Procedure:					
		lotify the physician of					
		ndition that may or may					
		ange in the treatment					
	<u>plan"</u>	at 0.05 a m. m1					
		at 9:05 a.m. record					
	review indicates	Resident # 22 has					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO.	NSTRUCTION 00	ì í	E SURVEY PLETED	
		155208	B. WIN			07/15/	2011
	PROVIDER OR SUPPLIER			410 W L	DDRESS, CITY, STATE, ZIP CODE AGRANGE ROAD ER, IN47243		
				<u> </u>			(7/5)
(X4) ID PREFIX		ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL	.D BE	(X5) COMPLETION
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
	diagnoses of, but	t is not limited to;					
	dementia, diabetes mellitus,						
	schizophrenia, ta	ardive dyskinesia,					
	coronary artery of	disease, and dysthmia.					
	Review of physic	cian orders dated					
		ated P.T., O.T. and S.T.					
	were to assess R	esident # 22.					
	Documentation v	was lacking that P.T.,					
	O.T., and S.T. ha	ad assessed the resident.					
		11:15 a.m. Licensed					
	l '	(L.P.N.) # 3 indicated that					
	l ' '	S.T. had not yet assessed					
	resident.						
		11:15 a.m. Medical					
	` ′	1 was observed to be on					
	the unit that Res	ident # 22 resides.					
		9:30 a.m. review of					
	1	cked documentation that					
		family had been notified					
		and S.T. had not assessed					
	Resident # 22.						
		10:15 a.m. review of the					
	physician progre						
		hat he had been notified					
	the assessment h	ad not been done.					
		35 p.m. review of the					
	1 *	CIAN & FAMILY					
	NOTIFICATION	N PROCEDURE indicated					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PMLR11 Facility ID:

000115

If continuation sheet

Page 5 of 53

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 07/15/2 0	ETED
NAME OF I	PROVIDER OR SUPPLIEF		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
HANOVE	ER NURSING CENT	ER		1	_AGRANGE ROAD 'ER, IN47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAU	"PURPOSE: To resident and fam condition change Telephone: 2. No change in condit warrant a change C. 1. During the between 9:15 a.r. #1 was observed	keep the physician, ily appraised of all es. PROCEDURE: otify the physician of any ion that may or may not e in the treatment plan." e initial tour on 7/11/11 n. and 10 a.m., resident propelling in a he time, the resident had		IAG	DETCHACT)		DATE
	reviewed on 7/12 resident's diagnor not limited to vermorbid obesity. note dated 6/01/2 by the physician limited to: "Plar (evaluation) re (roptions. Prognor obesity/venous shistory with treath hand written note [named] in therather strength of the control of t	ard for Resident #1 was 1/11 at 1 p.m. The ses included, but were nous stasis ulcers and A physician progress 11 at 11:20 a.m., signed included, but was not at Therapy eval regarding) footwear sis guarded due to morbid tasis and noncompliance timent." An undated, in indicated "Spoke with py will check on options 1) RN 6/1/11 2:30 p.m.					
	with Physical Th she had spoken v	:40 a.m., in interview erapist #1, she indicated, with the Social Worker in their scope of practice."					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII		INSTRUCTION 00	(X3) DATE S	ETED	
		155208	B. WIN			07/15/2	011
	PROVIDER OR SUPPLIER		-	410 W L	ADDRESS, CITY, STATE, ZIP CODE _AGRANGE ROAD		
HANOVER NURSING CENTER					/ER, IN47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	The Social Works indicated "she capay for them and order." The Dire present, indicated fell through the composition of the physical footwear options. C. 2. The clink Resident #91 to 7/12/11 at 3:10 re-write for ord June 2011 included to: "Extended to: "Extended to: Exercised for Market Medication Record for Market Ma	er was in the room and n't get shoes, she can't she did not see the ctor of Nursing, who was d'it was not done and racks." was lacking in the clinical sician being notified the had been obtained. hical record for was reviewed on 0 p.m. A physician ders signed and dated uded but was not telon (to treat mg (milligram)/24 ch apply 1 patch v day. Doc e. Remove old			CROSS-REFERENCED TO THE APPROPRIA	TE .	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/15/2011	
	PROVIDER OR SUPPLIER		410 W I	ADDRESS, CITY, STATE, ZIP CODE LAGRANGE ROAD /ER, IN47243	
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	Exelon 9.5 mg Patch not avai	g not available, 6/6 lable."			
	Nursing on 7/2 she could not of medication was ordered. She indicated days the MD value Documentation	rith the Director of 12/11 at 12:45 p.m., explain why the as not administered as if a resident misses 3 was to be notified. In was lacking in the s of physician/family			
F0160 SS=D	fund deposited wit must convey within funds, and a final to the individual or administering the Based on record facility failed to the state agency deceased residen	review and interview, the disperse resident funds to after death for 1 of 1 t account reviewed in a mple of 14 residents.	F0160	The facility will ensure this requirement is met through following corrective measu 1. Resident #91 is decease 2. All residents have the potential to be affected. Ba on audit of resident funds r further alleged deficient practice occurred. 3. The resident refunds for Medica Residents policy and	res. d. ased

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155208	A. BUII B. WIN			07/15/2011
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	LAGRANGE ROAD	
□ΛΝ Ο\/E	ER NURSING CENT	TED.		1	/ER, IN47243	
	- NORSING CENT	IER			FER, IN47243	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
	On 7/14/11 at 8:	18 a.m., Resident Trust			procedure was reviewed ar	
	Accounts were reviewed with the				revised. (See attachment C	;).
	Business Office	Manager.			Business Office staff was	
					inserviced on this procedu	I
	Resident #92, a Medicaid recipient,				The administrator or design will review resident trust fu	l l
	expired on $4/21/11$. The resident had a				balances weekly times 4 we	
	*				then monthly thereafter. (S	l l
	balance of \$52.00, in the trust, at the time				attachment D). 4. Findings	I
	of death. In interview with the Business				these audits will be reviewe	
	Office Manager at 8:20 a.m., she				during the facility's quarter	I
	indicated the \$52.00 was "applied to the				quality assurance meetings	\$
	nursing home bi	11."			and the plan of action adjus	sted
	In interview with the Bookkeeper, at this				accordingly. 5. The above	• • • • • • • • • • • • • • • • • • •
					corrective measures will be	
		ed she was instructed by			completed on or before Aug	gust
	· ·	ffice the funds remaining			14th, 2011.	
	1 ^	•				
		ed to the outstanding				
	nursing home bi	II.				
	On 7/14/11 at 1:	10 p.m., Administrator #1				
	provided the fac	ility's current undated				
	policy for "Resid	-				
	1 * *	ents" which included,				
	1	ted to: "Resident Expired				
		•				
		are no outstanding				
		(Accounts Receivable).				
		arges have been entered				
	1	hop, cable, etc. Send				
	balance inquiry t	to corporate biller for				
	approval before	sending personal funds				
	balance anywhere. If there are any					
	balances in A/R of any pay type then the					
		ent trust is to be deposited				
		A/R Account6. If there				
	are no outstandii	ng balances and if there is				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING				ETED	
		155208	B. WINC		- <u>-</u> -	07/15/2	011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE ROAD HANOVER, IN47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0250 SS=D	no surviving sporoutstanding funers send the remaining and/or credit balast Treasurer, State of 3.1-6(h) The facility must presocial services to a highest practicable psychosocial well-Based on record facility failed to esocial services were resident reviewed resident sample of Findings include: During the initial 9:15 a.m. and 10 observed propellist the time, the residence socks to both feet. The clinical record reviewed on 7/11 resident's diagnorate initial to ver morbid obesity, note dated 6/01/1	ase and there are no ral expenses, you must a resident trust funds ances in A/R to the of Indiana" Trovide medically-related attain or maintain the exphysical, mental, and being of each resident. The review and interview the ensure medically related ere provided for 1 of 1 dt for footwear in a of 15. (Resident #1) Tour on 7/11/11 between a.m., resident #1 was ang in a wheelchair. At dent had ankle length the resident #1 was and for Resident #1 was and	F02	250	The facility will ensure this requirement is met through following corrective measures. 1. Resident #1 h received shoes in accordan with her wishes. Physician aware the resident has footwear. 2. All residents h the potential to be affected. The administrator or design will review 5 resident charts weekly times 4 weeks then monthly x 2 months, then quarterly thereafter to ensu any social service needs ar addressed. (See attachmer E). 4. Findings of these aud will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before Aug 14th, 2011.	as ace ave 3. nee e nt dits	08/14/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	li i	e survey pleted /2011
	PROVIDER OR SUPPLIER		STREET.	ADDRESS, CITY, STATE, ZIP C LAGRANGE ROAD VER, IN47243	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	options. Prognos obesity/venous s history with treat hand written note [named] in thera noted (named) R p.m."	regarding) footwear sis guarded due to morbid tasis and noncompliance timent." An undated, the indicated "Spoke with the py will check on options of the complete times. No (RN #1) 6/1/11 2:30				
	with Physical Th she had spoken v and it was not "in scope of practice Director was in t "she can't get sho them" and she di Director of Nurs	erapist #1, she indicated, with the Social Worker in their (the therapists) "The Social Service the room and indicated bes, she can't pay for d not see the order." The ing, who was present, not done and fell iss."				
	reviewed on 7/11	ce Progress Notes /11 at 1 p.m., lacked a 11 related to obtaining				
	provided the sign Description for the Director, which is limited to "9. Er necessary person notifying familie	40 a.m., Administrator #1 ned and dated Job he Social Service ncluded, but was not asure residents have all al care items either by s or shopping for ommunicate with				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MI A. BUII B. WIN	LDING	00	(X3) DATE SURVEY COMPLETED 07/15/2011		
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER			•	410 W L	DDRESS, CITY, STATE, ZIP CODE AGRANGE ROAD ER, IN47243		
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F0253 SS=E	resident needs or Medicaid application that a service concern with intervention" 3.1-34(a) The facility must proportion of the facility must proportion a sanitary, orderly A. Based on obtain dinterview, the furniture, over the light covers were during environmed deficient practice residents in 12 or B. Based on obsthe facility failed was readily availed in the facility failed was readily availed in the presidents observed dining/activity residents dining/activity residents dining/activity residents dining/activity residents dining/activity residents din activity din activity residents din activity	problems (e.g., ations, legal aids, and promptly to a resident has a social warranting rovide housekeeping and ces necessary to maintain and comfortable interior. Servation, record review the facility failed to ensure the bed lights, and ceiling the clean and in good repair tental observations. This the affected 15 of 69 the cupied rooms. This deficient the small the small toom. This deficient the potential to affect 7 of 7 and during lunch and 9 of 9 and during supper in the poom.	F0	253	The facility will ensure this requirement is met through following corrective measu 1. The end cap on the hand was repaired. Room 24 bedframe was cleaned and light cover was repaired Room 17 ceiling light cover was replaced, bed was cleaned, cubicle curtain repaired A room 15 light b was replaced and marred a repaired Room 50, 51 and bed frames were cleaned Room 34 frame was cleaned chest of drawers was remover bed lights cleaned. Cubicle curtain repaired. Room 47 frame and over be lights were cleaned. Cubicle curtain repaired Room 46 frame cleaned. Cubicle curtain repaired. Room 46 frame cleaned. Room 47 frame and over be lights were cleaned. Cubicle curtain repaired. Room 46 frame cleaned. Room 46 frame cleaned. Room 44 be	res. I rail ulb reas 49 d, ved, ed e bed tain ack	08/14/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155208	B. WIN	IG		07/15/2011
NAME OF I	PROVIDER OR SUPPLIEF	3		1	ADDRESS, CITY, STATE, ZIP CODE _AGRANGE ROAD	
HANOVE	ER NURSING CENT	ΓER		1	ER, IN47243	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	10:55 a.m., the f	following was observed:			frames and bed light was	
					cleaned Room 43 bed fran	nes
	1. The end cap of	on the hand rail was loose			was cleaned, caulking was replaced around the base o	
	on the hallway w	with social service office			the toilet on, the orange	"
	and leading towa	ards the secured unit.			substance on the floor was	
					cleaned Room 41 bed fran	I
	2 Room 24O	ne bed frame was soiled			and bed light was cleaned.	The
		The ceiling light cover			closet doors were replaced	
	was loose.	The centing right cover			The ceiling light cover in th	e
	was loose.				hall outside the Dining/Acti	vity
	15 T				room was replaced A call	
3. Room 17Two ceiling lights lacked a					system has been implemen	I
cover, one bed was soiled with heavy dust				in the small dining room to		
	that rolled when swiped with the fingers. The cubicle curtain on one bed failed to				include call bells and a pho is in the adjacent dining roo	
					with posted instructions for	I
	enclose the bed	when pulled to provide			use. 2. All residents have t	I
	privacy.				potential to be affected. 3.	
	F				cleaning schedule and	
	 1	e light bulb in 1 ceiling			preventative maintenance	
		re the hand sink flashed			schedule have been review	ed.
	1 -	covering was marred			Housekeeping staff have be	I
		•			reinserviced on the cleanin	·
		ext to the floor 1 inch in			schedule. (See attachment	
	6 areas.				The maintenance superviso	
					has been re-educated on the preventative maintenance	l c
	5. Room 51 T	he frame of one bed was			schedule. (see attachment	
	soiled with heav	y dust.			Ga).Housekeeping supervis	I
					or designee will complete	
	6. Room 50 T	he frame of one bed was			environmental audits daily	
	soiled with heav				during scheduled working	days
		y 			x 4 weeks then weekly x 4	
	7 Room 40 Th	e frames of both beds			weeks then monthly therea	fter.
					(See attachment G) The	
	were soiled with	neavy dust.			administrator of her design	I
					will check the PM log and n	I
		e frame of one bed was			facility rounds weekly for to months then monthly	WU
	soiled with heav	y dust. A chest with 4			ondia dien mondiny	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155208	B. WIN			07/15/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
LIANOVE		TED		1	LAGRANGE ROAD	
	R NURSING CENT			HANOV	'ER, IN47243	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG		,	+	IAG	thereafter to ensure conce	
		finish missing on 3			are addressed timely (see	1115
		uter corners. Two over			attachment G).4. Findings	of
	_	ere soiled with heavy dust.			these audits will be reviewe	ed
		ain was short and failed			during the facility's quarter	-
		d and the curtain track			quality assurance meeting	
	was loose from the	ne ceiling.			and the plan of action adju accordingly. 5. The above	
	0.5.45.55				corrective measures will be	
		e frame of one bed and			completed on or before Au	
	two over the bed lights were soiled with heavy dust. The cubicle curtain for bed 2 failed to completely enclose the bed to provide privacy.				14, 2011.	
		he frame of one bed was				
	·	y dust. The cubicle				
		completely enclose the				
		A portion of the finish				
	* *	inch by 1 inch on the				
	ceiling by the cur	rtain track was missing.				
		1 0 0 1 1				
		he frames of two beds				
		bed light were soiled				
	with heavy dust.					
	10 D. 40 7	Fl C C				
		The frames of two beds				
		ed lights were soiled with				
	-	e caulking at the base of				
		athroom was stained.				
		the hand sink was stained				
	_	bstance approximately 6				
	inches.					
	12 5 44 7					
		The frames of two beds				
	and two over the	bed lights were soiled				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00		e survey pleted /2011	
	PROVIDER OR SUPPLIER		STREET 410 W	ADDRESS, CITY, STATE, ZIP CO LAGRANGE ROAD VER, IN47243	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	with heavy dust. the track on the r	The closet door was off ight side.				
		ht cover in the hall ning/Activity room was				
	the HouseKeepir July. The weekly follows: Monday Tuesday High Do Cans, Thursday window Blinds C Housekeeping D July 2011 provide each room was deach room wa	recount manager provided ag Project Calendar for y schedule was as y Bedframes Low Dust, ast, Wednesday Trash Tables & Chairs, Friday				
	between 9:15 a.m light was noted r small dining root It was again note observation on 7. a.m. and 12 p.m. On 7/12/11 at 5 p.m.	itial tour on 7/11/11 n. and 10:30 a.m., a call lear the entrance to the m with no cord attached. d during the lunch /11/11 between 11:30 with 7 residents present. lo.m., 9 residents were in room. The call light had				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2011	
	PROVIDER OR SUPPLIER		STREET.	ADDRESS, CITY, STATE, ZIP CODE LAGRANGE ROAD VER, IN47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
F0282 SS=D	#1 and #2 presses system and no ligheard. In interviewere not aware of had been out of some of the second of the second and the second and the second acabinet in the second of the 2 (two their wheelchairs and sample of the services proving accordance with plan of care. A. Based on robservation and facility failed to order for footward of 1 resident footwear and foot	d the button on the call ghts nor sounds were ew, at this time, they of how long the system ervice. 30 a.m., two bells were ond shelf from the top of mall dining room out of wo) residents seated in the conduction of the conduct	F0282	The facility will ensure this requirement is met through following corrective measu 1. Resident #1 has receive shoes of her wishes and the physician is aware. Reside #22 has been assessed by PT, and ST. Resident #91 is deceased. 2. All residents have the potential to be affected Nurse's Notes, MA and new physician orders were reviewed for past 30 of to ensure services were provided based on physician order or assessment, as	res: d e ent OT, s R's	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PMLR11 Facility ID:

000115

If continuation sheet

Page 16 of 53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION LIDENTIFICATION NUMBER: 155208			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155208	B. WIN	IG		07/15/2	011
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	DDRESS, CITY, STATE, ZIP CODE		
LIANOV/		ren		1	AGRANGE ROAD		
	ER NURSING CENT			HANOV	ER, IN47243		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAU			+	IAG	deemed necessary and in		DATE
interview, the facility failed to ensure the resident had been				accordance with the care p	olan.		
					3. The physician notification	on	
	assessed by oc	ecupational therapy,			with acute changes in		
	physical thera	py and speech therapy			condition (see attachment /	•	
	as ordered by	the physician upon			medication administration (attachment I); physician's	See	
	admission ord	1 7			orders (See attachment J)		
		ewed for therapy in a			policy and procedures were		
		(Resident #22)			reviewed and no changes v	vere	
	sample of 15.	(Resident #22)			indicated at this time. Licensed staff were		
	Findings include:				re-educated on the		
					procedures. The DON or he	er	
					designee will review Nurse	s	
	A.1. During the initial tour on				Notes and new physician		
	7/11/11 betwe	en 9:15 a.m. and 10			orders daily on scheduled v		
	a m resident	#1 was observed			family members are notified		
	•	a wheelchair. At the			timely with changes and		
					condition and that adequate		
	1	lent had ankle length			follow-up/through is compl when new orders are obtain		
	socks to both	feet.			(See attachment B) The DO		
					designee will audit MAR's t		
	The clinical re	ecord for Resident #1			times weekly for one month	١,	
	was reviewed	on 7/11/11 at 1 p.m.			then twice weekly for one		
		diagnoses included,			month, then weekly for one month, then monthly theres		
		imited to venous			to ensure medications are		
					given as ordered and, if hel	d,	
		nd morbid obesity. A			proper physician notification	on is	
		gress note dated			made and noted (see attachment Z).4. Findings	of	
		20 a.m., signed by the			these audits will be reviewe		
	physician, inc	luded, but was not			during the facility's quarter		
	limited to: "P	lan: Therapy eval			quality assurance meetings		
		e (regarding) footwear			and the plan of action adjus	sted	
	, ,	nosis guarded due to			accordingly. 5. The above corrective measures will be		
	options. Trog	110515 Suulded due to			Corrective incasures will be	,	

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE COMP 07/15/2	LETED
	ROVIDER OR SUPPLIER		410 V	TADDRESS, CITY, STATE, ZIP CODE V LAGRANGE ROAD DVER, IN47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	morbid obesity noncompliance treatment." A written note in [named] in the options noted 6/1/11 2:30 p.m. On 7/12/11 at interview with #1, she indicate with the Social not "in their (to of practice." To was in the root can't get shoes them and she of The Director of present, indicate and fell through A.2. The climic Resident #91 to 7/12/11 at 3:10 indicated the record of the proof of the proof of the proof of the present indicated the record of the proof of the present indicated the record of the present indicated the record of the proof of the present indicated the record of the present included but we have the present indicated the present included but we have the present indicated the record of the pre	y/venous stasis and e history with n undated hand idicated "Spoke with erapy will check on by (named) RN m." 11:40 a.m., in Physical Therapist red, she had spoken I Worker and it was he therapists) scope The Social Worker m and indicated "she s, she can't pay for did not see the order. of Nursing, who was ated "it was not done sh the cracks."		completed on or before 14th, 2011.	August	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155208			LDING	NSTRUCTION 00	(X3) DATE COMPL	LETED	
	PROVIDER OR SUPPLIER		p. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE LAGRANGE ROAD ER, IN47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	apply 1 patch 1	HR (hour) patch topically every day. at) site. Remove old 12/09/2010."					
	Record for Ma 2011 included to: Exelon Pat 31, June 2, 3, 4 12, and 16. The June 2011 form	on Administration by 2011 and June but was not limited tch not given on May 4, 5, 6, 7, 8, 9, 10, 11, he reverse side of the m indicated "6/2 g not available, 6/6 lable."					
	Returned Med Credit form da but was not lin	expired on 6/17/11. A cications Request for leted 6/18/11 included, mited to: Exelon 9.5 ch; date filled 5/31;					
	Nursing on 7/1 she could not of medication was ordered. B. On 7/13/20	ith the Director of 12/11 at 12:45 p.m., explain why the is not administered as 011 at 9:05 a.m. indicated Resident #					

A BUILDING B. WING COMPLETED 07/15/2011 NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 22 had diagnoses of, but was not limited to, dementia, diabetes mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to assess Resident # 22.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 22 had diagnoses of, but was not limited to, dementia, diabetes mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to	AND PLAN	OF CORRECTION		A. BUI	LDING	00		
HANOVER NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 22 had diagnoses of, but was not limited to, dementia, diabetes mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to			133200	B. WIN		DDDEGG GITTY GTATE ZID GODE	0771372	011
HANOVER NURSING CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 22 had diagnoses of, but was not limited to, dementia, diabetes mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to (X5) PREFIX CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION DATE (X5) COMPLETION DATE	NAME OF P	PROVIDER OR SUPPLIER			1			
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 22 had diagnoses of, but was not limited to, dementia, diabetes mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to	HANOVE	R NURSING CENT	ER					
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 22 had diagnoses of, but was not limited to, dementia, diabetes mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
22 had diagnoses of, but was not limited to, dementia, diabetes mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to		`				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	
limited to, dementia, diabetes mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to	TAG		, , , , , , , , , , , , , , , , , , ,	-	TAG	DEFICIENCY)		DATE
mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to		_						
dyskinesia, coronary artery disease, and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to		limited to, dementia, diabetes						
and dysthmia. On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to		mellitus, schiz	ophrenia, tardive					
On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to		dyskinesia, co	ronary artery disease,					
of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to		and dysthmia.						
of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to		, , ,						
of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to		On 7/13/2011	at 9:05 a m review					
6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to								
therapy (P.T.), occupational therapy (O.T.) and speech therapy were to								
(O.T.) and speech therapy were to		1						
Laggage Pacidant # 22		· /	1 3					
Documentation was lacking P.T.,		Documentation	n was lacking P.T.,					
O.T., and speech therapy had		O.T., and spee	ch therapy had					
assessed the resident.		assessed the re	esident.					
On 7/13/2011 at 11:15 a.m.		On 7/13/2011	at 11:15 a.m.					
Licensed Practical Nurse (L.P.N.) #		Licensed Pract	tical Nurse (L.P.N.) #					
3 indicated O.T., P.T., and speech		3 indicated O.	T., P.T., and speech					
therapy had not yet assessed			•					
resident.			J					
		, , , , , , , , , , , , , , , , , , , ,						
On 7/13/2011 at 12:40 p.m. in		On 7/13/2011	at 12:40 n m in					
interview with P.T. # 1 and O.T. #			_					
1, they indicated they had not			•					
received an order to assess Resident								
# 22. O.T. # 1 indicated the primary								
speech therapist # 1 was on		speech therapi	st # 1 was on					
vacation, and in her absence speech		vacation, and i	n her absence speech					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION OO			(X3) DATE S COMPL		
		155208	A. BUII B. WIN			07/15/2	
	PROVIDER OR SUPPLIER		D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE _AGRANGE ROAD /ER, IN47243		
(X4) ID PREFIX TAG	(EACH DEFICIENG REGULATORY OR therapist # 2 w	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Tas seeing residents. Ated speech therapist		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	# 2 comes thre was not here o reviewed onlin documentation indicate speech Resident # 22.	ne times a week and n this day. O.T. # 1 ne records and n was lacking to n therapy had seen					
F0333 SS=D	referral not to O.T., P.T., and 3.1-35(g)(2) The facility must e	rse (R.N.) # 2 ays was too long for a have been made to I speech therapy. Insure that residents are ant medication errors.	F0	333	The facility will ensure this		08/14/2011
	ensure medica administered a physician. The resulted in a si error for 1 of 1 related to med	s prescribed by the e deficient practice gnificant medication 5 residents reviewed ication administration 15. (Resident #91)			requirement is met through following corrective measured: 1. Resident #91 is deceased: 2. All residents have the potential to be affected. MA were audited for the past 30 days to ensure medications were administered as order and, if held, proper physician otification was made and noted.3. The medication administration policy and procedure has been review and no changes were made (See attachment I). Nursing	res: d. R's) ; ed an	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		COMPL		(X3) DATE SURVEY COMPLETED		
THETETAL	or connection	155208	- 1	LDING		07/15/2011
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE _AGRANGE ROAD /ER. IN47243	
	SUMMARY S (EACH DEFICIENCE REGULATORY OR 1. The clinical #91 was review 3:10 p.m. The resident was ac physician re-ward dated Junewas not limited dementia) 9.5 HR (hour) pate topically every (document) sitt patch. started 1. Review of the Spectrum Drug 7/12/11 at 3:40 was not limited monitor cognit particularly me significant decimprovement memory improsubtle and that	Interest of Deficiencies CY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) I record for Resident Wed on 7/12/11 at Precord indicated the dmitted 2/10/03. A Prite for orders signed Particle for orders s		410 W I		p DATE or of for kly for Z). will lity' ce ction ne
	Record for Ma	n Administration by 2011 and June but was not limited				

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	(X2) MULTIPLE (A. BUILDING B. WING	OO OOO	(X3) DATE COMP: 07/15/2	LETED
	PROVIDER OR SUPPLIER		410 V	T ADDRESS, CITY, STATE, ZIP COE V LAGRANGE ROAD DVER, IN47243	DE	
HANOVE (X4) ID PREFIX TAG	summary s (EACH DEFICIENT REGULATORY OR TO: Exelon Pa 31, June 2, 3, 4 12, and 16. The Taylor Street Patch not available The resident executed Medical Returned Returned Medical Returned Medical Returned Ret	tatement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) tch not given on May 4, 5, 6, 7, 8, 9, 10, 11, the reverse side of the m indicated "6/2 g not available, 6/6 lable." xpired on 6/17/11. A ications Request for	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	but was not lin	nited 6/18/11 included, mited to: Exelon 9.5 ch; date filled 5/31;				
	Nursing on 7/she could not medication was ordered. She indicated three days the notified. Doctolacking in the	rith the Director of 12/11 at 12:45 p.m., explain why the as not administered as if a resident misses MD was to be amentation was Nurses's Notes of ily notification.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155208 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE ROAD HANOVER NURSING CENTER HANOVER, IN47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Each resident receives and the facility F0364 provides food prepared by methods that SS=E conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. The facility will ensure this Based on observation, record review and F0364 08/14/2011 requirement is met through the interview, the facility failed to ensure following corrective measures: food was prepared in a manner to preserve 1. No residents were harmed.2. nutritive value and flavor, in that recipes All residents receiving puree were not followed in 1 of 1 observation of diet have the potential to be preparation of pureed foods. This affected. 3. All cooks were in-serviced on the facility deficient practice had the potential to pureed policy. (See attachment affect 16 of 16 residents who received L) The dietary manager or her pureed diets. designee will observepuree preparation 5 x Findings include: per week, alternating between breakfast, lunch and supper for four weeks; then three times On 07/11/11 at between 10:30 a.m. and per week for 4 weeks, then 10:47 a.m., the following was observed weekly indefinitely (See during preparation of pureed foods. attachment M). 4. Findings of these audits will be reviewed during the facility's quality 1. At 10:30 a.m., cook #1, indicated she assurance meeting and the was pureeing foods for 16 residents. plan of action adjusted Using a 6 ounce scoop, she measured 16 accordingly. 5. The above portions of the Chicken Casserole into the corrective measures will be Robo Coupe (food processor) the scoops completed on or before August 14, 2011. lacked being completely full approximately 1/4 inch from the top of the scoop. She added 16 slices of bread and 7 cups of broth and processed the items and then placed in the steamer. 2. At 10:27 a.m., cook #1, again indicated she was preparing pureed carrots for 16 residents. She indicated she had already

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PMLR11

Facility ID:

000115

If continuation sheet

Page 24 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155208	B. WIN			07/15/2	011
		<u> </u>	p. ,,,,,		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			_AGRANGE ROAD		
	ER NURSING CENT	ΓER		HANOV	/ER, IN47243		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1	ngs and needed to prepare					
	8 more servings. Using a 4 ounce ladle						
		aced 8 servings in the					
		ded 3 and 2/3 cups of					
	broth and proces	sed. She indicated she					
	added the marga	rine while cooking the					
	carrots.						
	At 11:10 a.m., th	ne dietary manager					
	provided a copy	of the recipes for the					
	pureed casserole and carrots which were						
	reviewed at this same time						
		Same time					
	The recipe for th	e Pureed Casserole read					
	as follows:	te i diced Cusseloie icad					
	16 servings						
	_	la. 16 auga					
	Cooked Cassero	•					
	Bread: 16 slices	.					
	Broth: 8 cups						
	Cook #1, measur	red the portions of					
	•	a 6 ounce measure instead					
	_	neasure for a cup. The					
		8 cups of broth and only					
	7 were added.	o cups of broth and only					
	, were added.						
	Pureed Vegetable	es					
	16 servings						
	Cooked Vegetab	les: 8 cups					
	Broth: 1 -3/8 cu	•					
	Margarine: 1/2 c	_					
	141018011110. 1/2 0	мр					
	To complete the	additional 8 servings of					
	1 -	ook #1, placed 4 cups of					
	Pareca carrois Co	Jok II 1, praced + cups or					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED					
AND PLAN	OF CORRECTION	155208	A. BUII		00	07/15/2	
		100200	B. WIN		ADDRESS CITY STATE ZIR CODE	0771072	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LAGRANGE ROAD		
HANOVE	R NURSING CENT	ER		l	/ER, IN47243		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		the Robo Coupe, added					
	•	nd processed. She failed					
	to add the margarine as the recipe called						
		ore than the required					
	broth for 16 serv	ings.					
	3.1-21(a)(1)						
F0365 Each resident receives and the facility provides food prepared in a form designed to meet individual needs.		•					
		_					
		review, interview and	F0	365	The facility will ensure this		08/14/2011
		facility failed to ensure 1			-	requirement is met through the following corrective measures: 1. Resident #52 was not	
		sk for choking/coughing			_		
		sample of 15 residents,			1. Resident #52 was not harmed.2. All residents on a mechanically altered diet have		
	_	ect food consistency					
		2 meals observed.			the potential to be affected.		
	(Resident #52)				The Reading Tray Cards po and procedures were review	licy	
	Finding includes	:			with no changes made. (Se attachment N). Dietary staff were re-educated on this	е	
	Review of the cli	nical record for Resident			policy. The dietary manage		
	#52 on 7/13/2011	1 at 9:50 a.m., indicated	1		her designee will audit pure	ed	
	the resident had o				diets preparation 5 x week,	4	
	included, but wer	•	1		alternating between breakfa lunch and supper for 4 wee		
	•	nentia, cataracts, and			then 3 x per week x 4 weeks		
	status post cerebi	ral vascular accident	1		then weekly indefinitely (Se		
	(stroke).				attachment M).		
					Additionally, the DON or he	∍r	
	Review of the Ju	ly 2011 monthly	1		designee will audit 1 meal service per day for four wee	nke	
		indicated the resident			then weekly thereafter to	, no,	
		pureed diet due to being			ensure diets are served as		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED						
AND PLAN	OF CORRECTION	155208	A. BUILDING	00	07/15/2011			
		133200	B. WING	A DDDDGG GUTY GTATE GID GODE	01713/2011			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE ROAD					
HANOVE	R NURSING CENT	ER	HANOVER, IN47243					
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE			
	family member v #2 that the residence peaches instead of was supposed to	observation on 20 p.m., the resident's was overheard to tell CNA ent had received regular of pureed peaches like she have. Observation of the e CNA noted the bowl to		ordered (See attachment O 4. Findings of these audits be reviewed during the facility's quarterly quality assurance meetings and th plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before Aug 14, 2011.	e			
	indicated the resindave pureed peaces she had received indicated that this when he comes is	th the CNA at this time ident was supposed to ches not the regular ones. The family member also s happens on occasion n to feed the resident and staff to get her the						
F0366 SS=E	provides substitute value to residents Based on record interviews, the faresidents received items listed on the deficient practice residents in a san	nple of 15 residents and s in a supplemental	F0366	The facility will ensure this requirement is met through following corrective measu 1. No residents were harm All resident food preference were updated to reflect cur preferences. All alert and oriented residents select w they will be served at lunch	res: ed. es rent			

li ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETI	
		155208	B. WIN	IG		07/15/201	1
NAME OF	DROLUDED OD GUDDI IEI		-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	C		410 W L	AGRANGE ROAD		
HANOVE	ER NURSING CENT	TER .		HANOV	ER, IN47243		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID I			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	l c	OMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIA		TE	DATE
	reviewed for foo	d likes and dislikes.			and supper. 2. All residents	s	
	(Residents #9, 17, 74, 100, 101, 102, 103,				have the potential to be		
					affected. All residents have		
		07, 108, 109, 110, and			been interviewed for		
	111)				preferences and will be		
					re-interviewed on a quarter	ly	
					basis to ensure updates are	•	
	Findings include	y:			listed. 3. The Reading tray		
					cards policy and procedure		
	During the groun	meeting on 7/11/2011 at			was reviewed with no chan	~ I	
1:30 p.m., Residents #100, 101, 102, 103,				made (See attachment N).			
				dietary staff members were in-serviced on the above			
	104, 105, 106, 107, 108, 109, 110, and 111 indicated their likes and dislike for				policy. Nursing staff were a	len	
					educated to ensure that tra		
		ns were not being			cards are reviewed to ensu	· I	
	followed and wo	ould get served the items			likes and dislikes are honor	-	
	anyway. The res	idents indicated that their			prior to delivery. The dietar		
	dislikes were list	ted on the tray cards			manager or designee will a	-	
	dietary follows f	or each meal but that they			tray card accuracy and food	d	
	received the iten	_			preferences 5 x week,		
		is ally way.			alternating between breakfa		
	During the lunch	observation on			lunch and supper for 4 wee	ks;	
	During the lunch				then 3xweek for 4 weeks,		
		en 12:20 p.m. and 12:45			then weekly indefinitely (Se		
	1 * '	d main course was			attachment O). The DON or designee will audit 1 meal	iiei	
		ole" and the following			service per day during		
	was observed:				scheduled working hours fo	or	
	1. Resident #107	had received the			four weeks, then weekly		
	broccoli and chie	cken casserole although			indefinitely (See attachmen	t	
		icated she did not like			O). 4. Findings of these au		
	1 *				will be reviewed during the		
	broccoli. During an interview with the resident at 12:27 p.m., she indicated she				facility's quarterly quality		
					assurance meetings and th	e	
	would just pick i	ı out.			plan of action		
					adjusted accordingly. 5. The		
		had received the broccoli			above corrective measures v		
		serole although his diet			completed on or before Augu 14, 2011.	151	
	card had indicate	ed he did not like			17, 2011.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	COMPI		
11.15 12.11.	or conduction	155208	- 1	LDING		07/15/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				AGRANGE ROAD		
HANOVE	ER NURSING CENT	ER		1	ER, IN47243		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION CONTROL OF A COUNTRY A COUNTRY OF A C			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION
TAG		an interview with his		TAG	DEFICIENCY)		DATE
	I -	at 12:29 p.m., she					
		ave to just pick it out. She					
		at this happens a lot and					
	1	o tell the staff to get him					
		The family member was					
		ask a staff member to					
	-	sandwich as she did not					
	think the resident would have enough to eat after she picked the broccoli out.						
	eat after she pick	ed the broccon out.					
	3. Resident #74 had received the broccoli						
	and chicken cass	erole although his diet					
	card listed brocc	oli as a dislike. The					
	resident was obs	erved to not eat his meal					
	although he did i	not ask for anything else.					
	4. Resident #111	was observed to have					
	received the main	n course of chicken and					
	broccoli casserol	e but was heard to ask for					
	something else.	When interviewed about					
		and the reason for asking					
		e, the resident indicated					
		occoli and the kitchen					
	knew it.						
	5. Resident #104	's lunch tray was					
	observed to have	carrots on it as the					
	vegetable and the	e resident was overheard					
	to tell the staff "V	Well, they can just take					
	that back. I have	never eaten carrots."					
	During an interv	iew with him at 12:42					
	p.m., the residen	t indicated he had never					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155208	B. WIN			07/15/2	011
NAME OF I	PROVIDER OR SUPPLIER		-	1	ADDRESS, CITY, STATE, ZIP CODE		
1144101/5	ED MUDOINIO OFNIT	·		1	LAGRANGE ROAD		
HANOVE	R NURSING CENT			HANOV	'ER, IN47243		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	eaten carrots and	staff knew it.					
		iew with CNA#1 on					
	7/12/2011 at 12:10 p.m., she indicated						
	dietary was the n	nain one responsible for					
	· -	suring the diet cards were					
	followed but that	the nursing staff passing					
	the trays were als	so supposed to. She					
	indicated she had let a few things get by her yesterday and that she did not check						
	the tray cards like she should have.						
	During an intervi	iew with Resident #9 on					
	~	p.m., she indicated she					
		food dislikes and that					
		hen was aware of them,					
		receive those dislikes					
		receive mose distikes					
	anyway.						
	On 7/12/2011 at	2:55 p.m., the Business					
		-					
		presented a copy of					
	*	de #1's and Dietary					
	~ ~	job descriptions dated					
	l ' '	and 9/18/2009 (dietary					
	manager). Review	_					
	_	uded, but were not					
	limited to:						
		Aide: Essential					
	Responsibilities:	4. Review menus prior					
	to preparation of	food and inspect all trays					
	to ensure comple	tion and accuracy of					
	menu and diet pr	eferences" On					
		#1 was checked of as					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		A. BUILDING	X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE O7/15/201			
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COI LAGRANGE ROAD /ER, IN47243	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
		nted to "Inspecting Meal				
	job Functions:4 prepared and sermenu and diet proportion control p During an intervity Food Service on she indicated the selective menu a items with the he indicated that if the main course, i.e. casserole, then the some of the ingredislike list. She find did not go back a resident if they could the the course and dislikes and dislikes helping them with the course of the 7/listed "Chicken Course although to the service of the 7/listed "Chicken Course although to the service of the 7/listed "Chicken Course although to the service of the 7/listed "Chicken Course although to the service of the 7/listed "Chicken Course although to the service of the 7/listed "Chicken Course although to the service of the 7/listed "Chicken Course although to the service of the 7/listed "Chicken Course although to the service of the 7/listed "Chicken Course although to the service of the service o	new with the Director of 7/14/2011 at 1:40 p.m.,				
	1:55 p.m., indica "Broccoli and Ch During an intervi	ted it really was nicken Casserole. New with CNAs #3 and #4				
	on //14/2011 at	1:45 p.m., they indicated				

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPLI	
	155208		A. BUILDING B. WING 07/15/2011				
					DDRESS, CITY, STATE, ZIP CODE	01710120	
NAME OF PR	OVIDER OR SUPPLIER		410 W LAGRANGE ROAD				
	R NURSING CENT	ER	HANOVER, IN47243				
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)				E	COMPLETION DATE
		esidents could tell them	•	IAG	BHICKET	+	DATE
1		would like on their					
	selective menu ar						
		likes of the residents in					
I		ething different but was					
		-					
I	not always easy to do. They indicated the						
residents on pureed diets just get whatever was being pureed with no choice to pick another item if something was a dislike to them. CNA #3 further indicated that because the residents on the Alzheimer wing were unable to make a choice in their selective menus most of the time, it							
		ror process with the likes					
I	and dislikes.	for process with the fixes					
	una arsinco.						
	3.1-21(a)(4)						
- 00 / -	The facility must -			1		1	
		om sources approved or					
	local authorities; ar	ctory by Federal, State or					
		distribute and serve food					
	under sanitary con						ļ
		ation, record review and	F03	71	The facility will ensure this	41	08/14/2011
	*	ility failed to ensure			requirement is met through following corrective measures		
		ean and food was			1. No residents were harme		
		unitary conditions on 2 of			All areas of concern have b	een	
3 dietary observations. This deficient					corrected. The milk cooler		
		potential to affect 68 of			a thermometer. Dietary staf recording temperatures 2 x		
69 health center residents who					day. A cover was installed		
	meals from the ki	itchen.			the light in the freezer. The		
	Findings include:				the light in the freezer. The fan was cleaned. All ceiling vents were cleaned.2. All residents		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PMLR11 Facility ID:

000115

If continuation sheet

Page 32 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155208	B. WIN			07/15/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			1	LAGRANGE ROAD	
HANO\/E	R NURSING CENT	ED	HANOVER, IN47243			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					have the potential to be	
On $07/11/11$, between the hours of 9:22				affected. See below for		
	a.m. and 9:49 a.r	n., the following was			corrective measures.3. The	•
	observed:	,			Registered Dietician	
	00001104.				Consultant reviewed ware	
	1 The mills and	or looked a themse are stor			washing, pot and pan sanitation, recording of	
		ler lacked a thermometer			equipment temperatures ar	nd
		on the temperatures were			kitchen sanitation with all	
	taken this a.m., v	vas lacking.			dietary employees. The	
					cleaning schedule was revi	sed
	2. The light in the freezer lacked a cover. The temperature registered greater than				(see attachment Qa) and a	
					procedure for responding t	
	1 ^	3 thermometers. The			cooling equipment failure v	vas
		containers of ice cream			written and implemented (s	ee
	l *				attachment P). The Dietary	
		solid, but had ice crystals.			Manager or her designee w	ill
		pping from the ceiling.			complete sanitation	
	In interview with	the dietary manager at			observations and equipme	
	9:00 a.m. she ind	licated the concern was			audits daily Monday thru F	riday
	reported to main	tenance at 9:15 a.m., in			for 4 weeks, then	
	the morning mee	ting.			weekly indefinitely (See	<u> </u>
					attachment Q). 4. Findings these audits will be reviewe	I
	3 Four large de	ep and three small steam			during the facility's quarter	
	I -	as clean were soiled with			quality assurance meetings	- 1
	_				and the plan of action adjus	I
	food on the inne	r surfaces.			accordingly. 5. The above	
					corrective measures will be	
		as soiled with dust on the			completed on or before Augu	ıst
	fan blades and gi	uard. The dietary			14, 2011.	
	manager indicated the fan is cleaned every					
	2 weeks.	,				
	5. Two ceiling vents located over the clean side of the dish machine were soiled					
		dish machine were solled				
	with heavy dust.					
	6. At 11:23 a.m.	on 07/11/11, the freezer				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CO A. BUILDING B. WING	COMPLETED			
	PROVIDER OR SUPPLIER		410 W I	ADDRESS, CITY, STATE, ZIP COD LAGRANGE ROAD /ER, IN47243	DE T	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Fahrenheit. In in manager, at this maintenance che turned it back on indicated staff no and freezer temp arrive for work a temp was docum degrees on 07/11 7. At 12:40 p.m was again measure thermometers loof freezer and temp degrees F. on two one. The temper cooked pork meadietary manager indicated a refrige contacted. A copy of the region 07/13/11 and	sured 20 degrees nterview with the dietary time, she indicated cked the compressor and at 9:45 a.m. She further formally take refrigerator eratures, when they at 6:00 a.m. The freezer mented as minus zero //11. the freezer temperature for were three cated on shelving in the eratures measured 20 of and 24 degrees F on frature for package of frasured 28 degrees. The disposed of the pork and geration company was pair invoice was provided indicated "cleaned and adjusted the charge."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE ROAD HANOVER, IN47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F0406 SS=D	but not limited to, I speech-language therapy, and ment services for mentar retardation, are recomprehensive play provide the required services accordance with § a provider of speciservices. Based on record the facility failed followed up on rescreen a resident choking while ear positioning and/or to a decline in colleaning backward practice affected for therapy in a service affected for therapy in a service with the resident had or included, but we multi-infarct dem status post cerebre (stroke). On 3/29/2011, not compared to provide the status post cerebre (stroke).	pathology, occupational al health rehabilitative I illness and mental quired in the resident's an of care, the facility must ed services; or obtain the from an outside resource (in 483.75(h) of this part) from alized rehabilitative review and interviews, to ensure therapy eferrals from nursing to after an episode of ting and for wheelchair or a new wheelchair due ndition with increased ds. This deficient 1 of 2 residents reviewed ample of 15 residents. mical record for Resident at 9:50 a.m., indicated diagnoses which	FO	406	The facility will ensure this requirement is met through following corrective measurement. Resident #52 was scree by the speech therapist. 2. residents have the potential be affected 3. Facility there department has been educ on the facility screen/evaluation and documentation of services policy. (See attachment R). Administrator or her design will review requested there a screens daily, on schedule work days, during morning meeting until the screen has been completed to ensure screens are completed time. This will continue indefinitely (See attachment 4. Findings of these audits be reviewed during the faces quarterly quality assurant meetings and the plan of an adjusted accordingly. 5. The above corrective measures be completed on or before August 14th, 2011.	the ires: ned All al to apy ated The nee py d les ely. at S). at Side will all to a cition the	08/14/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE C A. BUILDING B. WING	00 (X3) DATE SURVEY COMPLETED 07/15/2011			
	PROVIDER OR SUPPLIER		STREET 410 W	CADDRESS, CITY, STATE, ZIP CO LAGRANGE ROAD OVER, IN47243	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	ability to sit upridocumented "pt [name of represe mobility companion chair]. OT [occupattempted multip limited success.] [at] this time. Wi following new woof company there custom tilt-in span Documentation of company's assessing wheel chair was presented by 7/13/2011 at 3:13. An interview with occupational there 7/13/2011 at 11:10 outside mobility week but did not with the therapis recommendation indicated all that who the company. During an interview 7/14/2011 at 9:13 resident was initiated.	of this outside mobility sment of the resident for a was lacking until a fax the corporate nurse on 5 p.m. dated 4/14/2011. The COTA #2 [certified rapist assistant] on 1.5 a.m., indicated the company came in every leave any kind of notes as as to what swere made. She was left was a list of y was seeing. The with COTA #1 on 5 a.m., she indicated the ally denied for the new me mobility company was				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155208	B. WIN			07/15/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIANOVE		TD.		1	LAGRANGE ROAD		
	ER NURSING CENT	ER		HANOV	/ER, IN47243		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG			-	IAG	DEFICIENCE (DATE
		In a second interview with COTA #2 at 9:18 a.m., she indicated the resident was					
	· ·						
		neelchair and it was being					
		ndicated that although a					
		received by the facility					
		ey did not keep them as					
	there was no reas	son to.					
	During an intervi	iew with the corporate					
	~	/2011 at 2:05 p.m., she					
	1 ^	dicaid system was going					
	through an updat						
		being obtained to					
		resident's wheel chair as it					
		originally. She indicated					
		was originally sent in					
		nied due to the codes not					
	being accepted a						
	1 ^	sent on May 20th to					
		he further indicated they					
	1	g for Medicaid to reply					
	I '	lthough the specialist					
	~	erapy group] was in the					
	l -	ek, she had not added the					
	1 1	ster of residents currently					
		yesterday - 7/13/2011.					
	being seen until	y 05t01ddy 7/15/2011.					
	During review of	f the nursing notes					
	_	1 and 7/13/2011, the					
	following entry v						
		p.m.]: when feeding res					
	1	this evening, res. noted					
	2	on liquids & food. Res					
	noted to lean hea	-					

l	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	ľ	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIEF		410 W I	DDRESS, CITY, STATE, ZIP COI LAGRANGE ROAD (ER, IN47243	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	repositioned repo	eated this"				
	Nursing [DoN] of she indicated that tendency to coug chart it as choking					
	nursing made a r Therapy Screen" ability to sit up r choking/coughin made another red Therapy Screen" in physical status to sit up right. D	er the choking incident, referral for "Request for due to a decrease in right and an increase in right and an increase in right and are increase in ability occumentation was lacking a screenings have been				
	7/13/2011 at 11: would have to lo	iew with COTA #2 on 15 a.m., she indicated she ok through the files to 15/27/2011 screens had				
	7/14/2011 at 9:1 therapy staff were screens for the 5 referrals. She ind therapy would he screen due to it i	iew with COTA #1 on 5 a.m., she indicated the re still looking for the /5 and 5/27/2011 dicated that speech ave been the one to do the involving the resident atting and that as far as she				

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	A. BUILDIN		STRUCTION 00	(X3) DATE S COMPLI 07/15/2 (ETED
		100200	B. WING _	REET AD	DDRESS, CITY, STATE, ZIP CODE	01/15/20	J11
NAME OF P	ROVIDER OR SUPPLIER				AGRANGE ROAD		
HANOVE	R NURSING CENT	ER	H/	ANOVE	ER, IN47243		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREI TA		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
F0425 SS=D	knew, the screen: During an intervitherapist on 7/14 indicated the resiby the Speech That the 5/5 and 5/27/to evaluate the rethe wheel chair a choking. 3.1-23(a)(1) The facility must pereidents, or obtain described in §483. facility may permit administer drugs it under the general nurse. A facility must proviservices (including accurate acquiring administering of all meet the needs of The facility must e of a licensed pharm consultation on all pharmacy services Based on record	and biologicals to its In them under an agreement In 175(h) of this part. The In unlicensed personnel to If State law permits, but only Isupervision of a licensed In procedures that assure the Interpretation of the provision and the provision and the provision of the provision of the provision of the provision and the provision and the provision and the provision of the provision of the provision of the provision and the provision and the provision and the provision and the provision of the provision and the provision and the provision and the provision and the provision of the provision and the	F0425		The facility will ensure this requirement is met through	the	DATE 08/14/2011
		cility failed to ensure properly disposed of			following corrective measures:		
	_	o pharmacy for 1 of 1			1. Resident #92 is decease and medications were	a	
	resident reviewed	d for disposition of			disposed of.2. All residents have the potential to be	•	
					P		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PMLR11 Facility ID: 000115 If continuation sheet

Page 39 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155208 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE ROAD HANOVER NURSING CENTER HANOVER, IN47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE medications in a supplemental sample of affected. An audit of all medication carts and 14. (Resident #92) medication rooms was conducted to ensure Findings include: all medications needing dispositon have been On 7/11/2011 at 12:20 p.m., medications in a timely manner. 3. Licensed nursing staff have been for Resident # 92 were in a bin in the re-inserviced on the medication room to be returned to medication destruction policy. pharmacy. These included Depakote (See Attachment T). The DON liquid dated 5/9/2011 approximately 11 or her designee will audit to oz., Glucagen 1mg injection for ensure medications are returned or destroyed in hypoglycemia dated 4/21/2011 and 2 accordance with facility policy bottles of Reglan dated 5/9/2011 and documented appropriately approximately 20 oz. weekly x 8 weeks, then monthly x2 months and On 7/11/2011 at 12:00 p.m., in interview quarterly thereafter. (See Attachment U) 4. Findings of with Licensed Practical Nurse (LPN) # 2, these audits will be reviewed she indicated medications were to be during the facility's quarterly returned to pharmacy within 7 days from quality assurance meetings being discontinued. and the plan of action adjusted accordingly. 5. The above On 7/11/2011 at 12:25 p.m., in interview corrective measures will be completed on or before August with LPN # 1, she indicated over the 14th, 2011. weekend she was cleaning out a medication cart and found the medication, when checking for discontinued and expired medication. LPN # 1 indicated Resident # 92 had expired "sometime end of May." On 7/11/2011 at 1:00 p.m., record review of facility's discharges over 90 days included; but was not limited to, Resident # 92 RHC'D (respirations have ceased)

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PMLR11

Facility ID: 000115

If continuation sheet

Page 40 of 53

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	(X2) M ¹ A. BUII B. WIN		STRUCTION 00		(3) DATE S COMPL 07/15/20	ETED
	PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, Z AGRANGE ROAD R, IN47243	ZIP CODE		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN O (EACH CORRECTIVE ACT	TION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO DEFICIENCE	CY)		DATE
	May 27, 2011.		İ					
F0428 SS=D	Of Nursing (DO) and Procedure for OF MEDICATIO was not limited to which there is not destroyed at the possible, but not (7) days of become Procedure-A, 1. It medication become charge nurse or charge nurse or charge nurse of the remaining do Disposal Log (sandestroy the medications must do and the company of the company of the company of the company of the remaining do Disposal Log (sandestroy the medications must do and the company of th	indicates, "as soon as a mes inactive, the unit lesignee should remove e drug from stock, count ses, fill out the Drug mple on page 90), and cation. 4. Oral solid ould be flushed down a lamay be flushed or						
	Based on record	review and interview, the	F0	428	The facility will e requirement is n		he	08/14/2011
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	PMLR11	Facility ID		If continuation shee		l ge 41 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155208	B. WIN	IG		07/15/2011
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
				1	LAGRANGE ROAD	
HANOVE	ER NURSING CENT	ER		HANOV	/ER, IN47243	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
	1	ensure consultant			following corrective measu 1. Resident #58 Omeprozo	I
	pharmacy recom				Alamag, PRN Tylenol, and	ie,
	discontinuing du	•			Guaifenesin was discontin	ued
	unnecessary ston	nach medications and			in accordance with pharma	
	-	needed] medications			recommendations. 2. All	
	were acted upon	for 1 of 15 residents			residents have the potentia	
	reviewed for pha	rmacy recommendations			be affected. An audit of the	9
	in a sample of 15	residents. (Resident			last 90 days of pharmacy recommendations was	
	#58)				completed to ensure all ha	4
					been addressed with the	"
	Finding includes	:			physician as indicated.3.	he l
					DON was inserviced on tim	l l
	Review of the cli	inical record for Resident			pharmacy recommendation	l l
		1 at 11:00 a.m., indicated			follow-up. The Administration	l l
	the resident had	·			or her designee will review	l l
		re not limited to, hiatal			pharmacy recommendation reports monthly upon arriv	l l
	hernia and divert	*			the facility, following up da	l l
	nemia and divert	iculai disease.			until the recommendation i	
	On 7/12/2011 at	2.25 mm the DeN			addressed monthly for thre	e
		2:35 p.m., the DoN			months then quarterly	
	-	sing] presented the			thereafter (See attachment	
	following consul	•			4. Findings of these audits	l l
	recommendation	S:			be reviewed during the fac s quarterly quality assuran	-
		W/D 11 01			meetings and the plan of a	
		"(Resident) has orders			adjusted accordingly. 5. The	l l
	for routine Omep	` •			above corrective measures	
	[milligrams] dail	-			be completed on or before	
	1 .	ıl reflux disease] -			August 14th, 2011.	
	ordered 7/1/10) A	AND Pantoprazole (40				
	mg daily for GEI	RD - ordered 12/15/10).				
	Will you please I	D/C [discontinue] one of				
	these medication	s, as they are both in the				
	same class (proto	on pump inhibitors) and				
	, a	cations is a duplication in				
	therapy.					

li 1		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 07/15/2	LETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE AGRANGE ROAD ER, IN47243	07710/2	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	following routing Alamag Plus lique [milliliters] PO Titimes daily]. 2. Simethicone 8 of these medicativilly ou consider liquid (aluminum hydroxide do not may be unnecess keeping only her 3. On 6/13/2011: following PRN in Acetaminophen at tabs (650 mg) Queceives routine and Guaifenesin 100 (200 mg) PO q 4 [upper respirator these medication least 60 days, with D/Cing these order the presented she indicated the recommendation upon yet as she and said and sai	O mg TID. Because both ions contain simethicone, in D/Cing her Alamag in and magnesium a provide gas relief and it is imethicone tablets? "(Resident) has the inedication orders: 1. [APAP] 325 mg tabs - 2 [every] 4 PRN painalso APAP 650 mg Q AM. 2. mg/5 ml syrup - 10 ml h (hour) PRN cough/URI by infection] (1/25/11). If it is have not been used in at at at all you please consider iters? The with the DoN at the end the recommendations, is sepharmacy is had not been acted and fallen behind in some. It is attention in the pharmacist in the pharmacist in the provided in the pharmacist in the pharmacist in the provided in the pharmacist					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	A. BUILDING B. WING	00 CONSTRUCTION	07/15/	LETED
	PROVIDER OR SUPPLIER		410 V	TADDRESS, CITY, STATE, ZIP CO V LAGRANGE ROAD DVER, IN47243	JDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F0514 SS=D	each resident in a professional stand complete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission screed State; and progreed Based on record facility failed to accurate assessminad experienced while eating. This affected 1 of 15 m complete and according includes. Finding includes Review of the climate of 15 m complete and according includes. Review of the climate of 15 m complete and according includes. Review of the climate of 15 m complete and according includes.	review and interview, the document a complete and ent of a resident after she an episode of choking s deficient practice residents reviewed for curate records in a sample Resident #52) : inical record for Resident 1 at 9:50 a.m., indicated diagnoses which	F0514	The facility will ensurequirement is met to following: 1. Reside assessed upon notification the incident and suffinegative outcome. 2. residents have the pole affected. See bel corrective measures Clinical documentation and procedure policical reviewed and no charmade (see attachme Licensed staff were re-educated on the procedure. The DOM designee will review Notes daily during some working days to ensuppropriate, thoroug timely assessment is completed and documented in the renotes. (See attachmented)	chrough the cent #52 was fication of fered no All cotential to low for 3 ion policy by was langes anges ion there of Nurse's cheduled cure gh and a	08/14/2011

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

l '		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155208	A. BUILDING	00	07/15/2011	
		133200	B. WING		0771372011	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
HANOVE	R NURSING CENT	ER	l l	_AGRANGE ROAD 'ER, IN47243		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		1
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE	
		1 and 7/13/2011, the		Findings of these audits wi reviewed during the facility	•	
	following entry was noted:			quarterly quality assurance	l l	
		p.m.]: when feeding res		meetings and the plan of a	l l	
		this evening, res. noted		adjusted accordingly. 5. T	l l	
		on liquids & food. Res		above corrective measures	will	
	noted to lean hea			be completed on or before August 14th, 2011.		
	repositioned repe			August 14tii, 2011.		
		vas lacking by nursing of				
		ng been assessed right				
		for possible need for				
		/5/2011 nursing note was				
	•	hours after the incident				
	_	osted meal time for the				
	_	ere the resident ate was				
	5:40 p.m.					
	During on intervi	iew with the Director of				
	_	on 7/13/2011 at 2:00 p.m.,				
	• • •	t the resident has a				
		t the resident has a th and some staff will				
	chart it as chokin					
		g. that staff should have				
		ic in their documentation				
	of the incident.					
	or the includit.					
	3.1-50(a)(1)					
	3.1-50(a)(2)					
E0000						
F9999						
	STATE RULE FI	INDINGS	F9999	The facility will ensure this	08/14/201	11
				requirement is met through	n the	
	3.1-14 PERSON	NEL		following: 1. LPN #1's seco		
				step PPD was completed ti in accordance with state	mely	
				in accordance with state		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	(X2) MU A. BUIL B. WING	LDING G	NSTRUCTION 00	(X3) DATE: COMPL 07/15/2	ETED
	PROVIDER OR SUPPLIEF			410 W L	.ddress, city, state, zip code LAGRANGE ROAD 'ER, IN47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	for each employed (1) month prior to examination shares skin test, using to TU PPD), admindocumentation of department- apprintential department- app	radermal tuberculin skin and recording unless a ve reaction can be e result shall be recorded induration with the date and by whom he tuberculin skin test for to the employee he facility must assure the etime of employment, or nonth prior to did at least annually by east and nonpaid littles shall be screened. For health care workers did a documented negative est result during the etim skin testing should step method. If the first a second test should be to three (3) weeks after the frequency of repeat and on the risk of infection.			regulation and facility police. 2. All residents have the potential to be affected. A complete audit of employe files was completed to ensall emplopyees are in compliance. 3. The busine office personnel and staff development coordinator was reeducated on the employed health requirements policy. The administrator or her designee will audit new employee files to ensure her requirements are met week x2 weeks then monthly x 2 month and quarterly therea (See attachment X) 4. Find of these audits will be reviduring the facility's quarter quality assurance meeting and the plan of action adjutaccordingly. 5. The above corrective measures will be completed on or before Au 14th, 2011.	e ure ss vere ee . ealth kly after. lings ewed rly s sted	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208			(X2) MULTIPLE CC A. BUILDING B. WING	00	COMI	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		410 W I	ADDRESS, CITY, STATE, ZIP CO LAGRANGE ROAD /ER, IN47243	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	This State Rule v	was not met as evidenced				
	facility failed to screened for tube employment or v employment. The	review and interview, the ensure employees were erculosis at the time of within one month prior to his deficient practice employee files reviewed.				
	Findings include	:				
	_	w of the employee files ween 1 p.m. and . 2 p.m., s identified:				
	LPN (Licensed Practical Nurse) #1 with a start date of 6/15/11, lacked documentation of a second step screening for tuberculosis. The first tuberculin skin test was administered on 6/13/11 and read negative on 6/15/11.					
	Manager, on 7/13	a the Business Office 3/11 at 2 p.m., she cond step had not been				
	3.1-14(t) 3.1-14(t)(1)					
R0000						

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208		LDING	00	(X3) DATE S COMPL 07/15/2	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE ROAD HANOVER, IN47243				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0270	(c) The facility must (1) daily dietary rewith consideration (2) reasonable relipreferences; and (3) the temporary the resident's roc Based on record interviews, the faresidents received items listed on the deficient practice residential reside residential reside for food likes and #112, 113, and 1 Findings include During the lunch 7/11/2011 at 12:1 was observed to instead of the car	ate residential findings redance with 410 IAC st meet: quirements and requests, of food allergies; gious, ethnic, and personal need for meals delivered to om. review, observation and acility failed to ensure d substitutes for menued reir dislike list. This eraffected 3 of 8 ants in a sample of 8 ants who were reviewed dislikes. (Residents 14)		0000	Submission of this Plan of Correction does not constitute admission or agreement by provider of the truth of fact alleged or correction set for on the state of deficiencies. This Plan of Correction is prepared and submitted because of requires of State Federal law. Please accept plan of correction as our credible allegation of compliance. The facility will ensure this requirement is met through the following corrective measures and the following corrective measures are updated to reflect current preferences. All alert and or residents select what they we served at lunch and supper. All residents have the pote to be affected. All residents have been interviewed for preferences and will be re-interviewed on a quarter basis to ensure updates and listed. 3. The Reading tray cards policy and procedure was reviewed with no chain made (See attachment N). dietary staff members were in-serviced on the above	the is in the is in the is in the is in the	08/14/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED	
		155208	B. WIN			07/15/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	LAGRANGE ROAD		
HANOVE	ER NURSING CENT	ΓER		1	/ER, IN47243		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETIO DATE	JN
IAG			•	IAU			
		his tray indicated not only			policy. Nursing staff were a educated to ensure that tra		
		arrots, he also did not like			cards are reviewed to ensu	=	
		en interviewed at this			likes and dislikes are hono		
	time, he indicate	d this happens a bunch			prior to delivery. The dietar		
	and that if he did	ln't like it, he just would			manager or designee will a	·	
	not eat it.				tray card accuracy and foo	t t	
					preferences 5 x week,		
	During a second	interview with Resident			alternating between breakfa		
	_	11 at 10:00 a.m., he			lunch and supper for 4 wee	ks;	
		continually sends his			then 3xweek for 4 weeks,		
	1	even though he does not			then weekly indefinitely (Se attachment O). The DON or		
	1 ^	•			designee will audit 1 meal	ilei	
		s tray card likes them			service per day during		
	under his dislike	S.			scheduled working hours fo	or	
					four weeks, then weekly		
	During the group	o meeting on 7/11/2011 at			indefinitely (See attachmen	t	
	1:30 p.m., Resid	ents' #112 and 113			O). 4. Findings of these au	dits	
	indicated their li	kes and dislikes were not			will be reviewed during the		
	being honored a	nd that they would			facility's quarterly quality		
	_	ve food items listed as a			assurance meetings and th	е	
	dislike.				plan of action adjusted accordingly. 5. Th	20	
					above corrective measures v		
	During an interv	iew with CNA#1 on			completed on or before Augu		
	_	10 p.m., she indicated			14, 2011.		
		nain one responsible for					
	1 -	*					
	_	suring the diet cards were					
		t the nursing staff passing					
	1	so supposed to. She					
		d let a few things get by					
		d that she did not check					
	the tray cards lik	te she should have.					
	On 7/13/2011 at	2:55 p.m., the Business					
		presented a copy of					
		de #1's and Dietary					

PRINTED: 08/16/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00		(X3) DATE SURVEY COMPLETED			
		155208	A. BUI B. WIN	LDING		07/15/			
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>			
NAME OF PROVIDER OR SUPPLIER				410 W LAGRANGE ROAD					
HANOVER NURSING CENTER				HANOVER, IN47243					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECT		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION		
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	IAG	BEITGERIOTY		DATE		
	manager's signed job descriptions dated								
	1/27/2010 (cook) and 9/18/2009 (dietary manager). Review of these job descriptions included, but were not limited to:								
	1. "Cook/Dietary Aide: Essential								
	Responsibilities:4. Review menus prior								
	to preparation of food and inspect all trays								
	to ensure completion and accuracy of								
	menu and diet pr								
	1/29/2010, Cook #1 was checked of as								
	having been oriented to "Inspecting Meal								
	Trays for Accuracy".								
	2. "Director of Food Service:Essential								
	job Functions:4. Ensure meals are								
	prepared and served in accordance with								
	menu and diet preferences and established								
	portion control procedures."								
	During an interview with the Director of								
	Food Service on 7/14/2011 at 1:40 p.m.,								
	she indicated the residents have a								
	selective menu and will choose their own								
	items with the he	elp of nursing staff. She							
	indicated that if	the residents choose the							
	main course, i.e.	broccoli and chicken							
		ney get the item even if							
	I -	edients was on their							
		urther indicated that she							
	_	and double check with the							
	resident if they circled a disliked item and								
	that it was up to	the CNAs to know the							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155208 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE ROAD HANOVER NURSING CENTER HANOVER, IN47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE likes and dislikes of the residents when helping them with their selective menus. Review of the 7/11/2011 menu for lunch listed "Chicken Casserole" as the main choice although the recipe presented by the Director of Nursing on 7/13/2011 at 1:55 p.m., indicated it really was "Broccoli and Chicken Casserole. (a) The facility must maintain clinical records R0349 on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. R0349 The facility will ensure this 08/14/2011 Based on record review and interview, the requirement is met through the facility failed to document complete eye following corrective measures: doctor recommendations for 1 of 1 1. Resident resident reviewed with recommendations #77's recommendations were in a sample of 7. (Resident #77) addressed. 2. All residents have the potential to be affected. MD progress notes Findings include: and consult notes were reviewed for all residents for The clinical record for Resident #77 was the past 60 days to ensure reviewed on 7/13/11 at 9:10 a.m. The recommendations have resident was admitted to the residential been addressed. 3. Licensed staff were re-educated on the unit on 7/1/11. A Report of Consultation need to review all progress dated 7/11/11 included, but was not notes and consult notes to limited to: Recommendations Follow up ensure that recommendations in 6 months; 1. AREDS vitamin daily; are addressed timely. The DONor her designee will

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PMLR11

Facility ID:

000115

If continuation sheet

Page 51 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155208 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE ROAD HANOVER NURSING CENTER HANOVER, IN47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 2. Tears ou (both eyes) 4 - 6 x/day review progress notes and consult notes weekly for 4 (times/day). weeks, then monthly indefinitely to Review of the July Medication ensure recommendations are Administration Record lacked the vitamin addressed timely (See and tears orders. In interview with attachment K). 4. Findings of these audits will be reviewed LPN#2, she indicated the orders had not during the facility's quarterly been completed. At 10 a.m., LPN #2 quality assurance meetings provided a Comprehensive Physician's and the plan of action adjusted Order Sheet for "Eye Caps (AREDS accordingly. 5. The above Vitamin) i (one) po (by mouth) daily. corrective measures will be completed on or before August Artificial tears i drop both eyes QID (4 14th, 2011. times a day)...." (h) Current clinical records shall be completed R0355 promptly, and those of discharged residents shall be completed within seventy (70) days of the discharge date. Based on record review and interview the R0355 The facility will ensure this 08/14/2011 requirement is met through the facility failed to ensure the clinical following corrective measures: records were completed promptly after a 1. Resident #80 continues to resident's discharge for 2 of 2 closed reside on the health care unit. records reviewed in a sample of 7. 2. All residents have the (Resident #80, #81) potential to be affected. 3. Clinical documentation policy and procedure policy was Findings include: reviewed and no changes made (see attachment W). 1. The clinical record for Resident #80 Licensed staff were was reviewed on 7/13/11 at 11:20 a.m. re-educated on the requirements related to a The resident was discharged from the discharge assisted living wing to the long term Wing documentation/transfer of level 4 on 1/5/11. Documentation was lacking of care documentation. The of a physician order and Nurse's Notes DON or her designee will related to the discharge. review discharged/transferred records to ensure phsycian

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		A. BUILDING B. WING			COMPLETED 07/15/2011		
HANOVE	PROVIDER OR SUPPLIEF	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE ROAD HANOVER, IN47243				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	was reviewed on The resident was assisted living w Wing 4 on 1/5/1 lacking of a phys Notes related to In interview with on 7/13/11 at 2 p discharge summaresident. In interview with 7/13/11 at 2 p.m told by the Provi [name] from the of Health indicated (1) license the charge in the charge summaresident back and the serious s	ecord for Resident #81 1.7/13/11 at 11:20 a.m. It discharged from the sing to the long term care I. Documentation was sician order and Nurse's the discharge. In the Director of Nursing a.m., she indicated no aries were done on either In Administrator #1 on a, she indicated she was der Representative, Indiana State Department the different and not have to ident and reopen a clean			orders for the discharge/transfer are obt and documentation regard the reason for transfer or discharge is documented clinical record prior to discharge/transfer weekly weeks, then monthly x2 months, then quarterly indefinitely (See attachme Y). 4. Findings of these a will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before Au 14th, 2011.	ling in the x 2 ent udits e	